

Authorization to Release Health Information

Expires upon one time release

Name _____ dob ____/____/____

Address _____

I authorize the practice below to release my health information:

Please forward/release my health information to:

ALLAYANT PAIN MANAGEMENT
2270 HENDERSONVILLE ROAD, SUITE 1
ARDEN, NC 28704
828 376-0001 866 922-8588 toll free fax

The information below is provided at the request of the patient. (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> last treatment note or summary of care | <input type="checkbox"/> pharmacy records |
| <input type="checkbox"/> pain evaluation/treatment | <input type="checkbox"/> lab work |
| <input type="checkbox"/> radiology reports including MRI/CT | <input type="checkbox"/> post operative summary |
| <input type="checkbox"/> other as specified _____ | |

This authorization shall be in effect until the information has been forwarded as requested.

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document.

Signature of Patient or Personal Representative _____ date _____

Description of Personal Representative's Authority (attach necessary documentation)